Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

## I. DISPUTE

1. a. Whether there should be additional reimbursement of $233.00 for date of service 10/05/01, per the new Table of Disputed Services.

   b. The request was received on 06/21/02.

## II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Letter Requesting Dispute Resolution
   b. HCFA(s)
   c. TWCC 62 forms
   d. New Table of Disputed Services faxed 01-29-03
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II: No response found in case file.

3. Per the Texas Workers' Compensation Commission's Case Activity Log, reflected in Exhibit III, "14 day letter mailed 7/11/02; HCP has not submitted additional info; Therefore, there will be no signature memo from IC; forwarding to Waco for review."

## III. PARTIES' POSITIONS

1. Requestor: Letter regarding date of service 10/05/01.

   "Per Spine Treatment Guideline (T)(i) ESI must be under fluoroscopic control. We are asking for full reimbursement of our usual and customary/DOP and not another codes value (76000-$88.00). DOP provides the complexity and value of our service. Please refer to Advisory 97-01."

2. Respondent:

   The Respondent did not submit a letter of response to dispute resolution.

## IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 10/05/01.

2. For the date of service 07/25/01, the provider's representative, per a phone conversation, indicated that the only date of service in dispute is 10/05/01, in the amount of $233.00, per the new table faxed on 01/29/03.

3. The denial codes listed on the alternate TWCC 62 are "F-REDUCTION ACCORDING TO FEE GUIDELINES. T-THE PROCEDURE CODE SUBMITTED IS NOT THE PROPER CODE FOR THIS SERVICE. PLEASE RESUBMIT WITH THE PROPER CODE"

4. The following table identifies the disputed services and Medical Review Division's rationale:

| DOS | CPT or Revenue CODE | BILLED | PAID | EOB Denial Code(s) | MAR$ | REFERENCE | RATIONALE: |
|---|---|---|---|---|---|---|---|
| 10/05/01 | 76499-27 | $350.00 | $0.00 | T | DOP | MFG, GI (I)(A&B), STG 134.1001 (e)(T)(i) CPT & modifier descriptors | The carrier has denied the charges in dispute as "**F-REDUCTION ACCORDING TO MEDICAL FEE GUIDELINES**." Carrier's response is timely and no other EOB's or reaudits were noted. Therefore, the Medical Review Division's decision is rendered based on denial codes submitted to the Provider prior to the date of this dispute being filed. According to the Spine Treatment Guidelines rule 134.1001(e)(T)(i): "ESIs must be performed under fluoroscopic control." The CPT descriptor states, "Unlisted diagnostic radiologic procedure." The MFG GI (I)(A) states, …(TWCC) has incorporated usage of the …(AMA's) 1995 …(CPT) codes. The MFG has CPT code 76000 which has the descriptor: "Fluoroscopy (separate procedure), up to one hour physician time, other than 71023 or 71034 (eg. cardiac fluoroscopy)." The CPT code 76000 is sufficiently descriptive of the procedure performed and should have been used. The MAR value of 76000-27 is $88.00. Therefore, no reimbursement **is** recommended. |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 10/05/01 | A4550 | $145.00 | $0.00 | F | DOP | MFG,SGR (V)(B(1) | **"Surgical Procedures performed in a Doctor's Office:**<br>B. If the above listed requirements are met, the only reimbursements allowed for facility charges shall be the following:<br>1. Sterile trays (which include all supplies, gloves, utensils, needles, suture material, etc., needed to perform the procedure). These shall be billed using 99070-ST. Reimbursement is the lesser of the doctor's usual charge or fair and reasonable reimbursement. DOP is required if charges are $50.00 or greater."<br>The provider billed A4550, which is a HCPCS code for sterile tray. The provider has indicated, per a phone conversation on 01/29/03, that they are a doctor's office. Therefore, the MFG code 99070-ST should have been used for the billing in a doctor's office.<br>Therefore, no reimbursement is recommended. |
| **Totals** | | $495.00 | $0.00 | | | | The Requestor **is not** entitled to reimbursement. |

The above Findings and Decision are hereby issued this 30th day of January, 2003.

Michael Bucklin
Medical Dispute Resolution Officer
Medical Review Division

MB/mb